LOWELL CHC HEALTH CENTER

MATHES, MARGARET

Guarantor: MATHES, MARGARET Insurance: NATIONAL GOVERMENT SERVICES Payer ID: 06001
PCP: LCHC LCHC External Visit ID: 1142550
Appointment Facility: METTA Health Center

11/06/2014

Progress Notes: Maria Gayanilo, MD

Current Medications

Past Medical History
11/2011: carotid doppler - normal (Saints)
10/2011: MRI brain - lacunar infarct a right sup lateral ventric margin with smaller lesion on right parietal white matter
9/2011: CT head - small old lacunar infarct - right corona radiata; no acut abn
5/2013: declines mammogram, pap, dexa scan
5/2013, 8/2014: stool guniac neg

Surgical History
hemorrhoids 1982

Family History
Partner: deceased
Father: deceased
Mother: deceased
Paternal Grand Father: deceased
Paternal Grand Mother: deceased
Maternal Grand Father: deceased
Maternal Grand Mother: deceased
Siblings: alive
Children: alive
1 sister(s) - healthy. 2daughter(s) - healthy.
no known cancers/stroke/heart disease/diabetes.

Social History

Review of Systems
RESPIRATORY:
no Shortness of breath.
CARDIOVASCULAR:
no Chest pain. no Leg edema.
GASTROINTESTINAL:
no Abdominal pain. Constipation yes.
NEUROLOGY:
dizziness yes.
PSYCHOLOGY:
sleep disturbances yes, unable to fall asleep at night - improved with melatonin.

Reason for Appointment
1. 68 yrs old female presents today for f/u. request med. refill.>cven,ma

History of Present Illness
Interpreter:
Interpreter Use By Provider of Care.
Constitutional:
-Came with daughter for ff-up and refill of meds.
Pt will be moving to daughter's house due to being forgetful. Has seen NEURO and currently on donepezil. Pt's daughter is planning to apply as pt's caretaker.
-Pt is requesting refill of constipation meds and if doses can be changed as her stools are still hard. She moves bowels daily.
-Still has occasional vertigo symptoms (dizziness) and sx relieved with prn antivert - pt is requesting refill of med.

Vital Signs
Height 60, Weight 164.2, Weight Change 1.2 lb, BMI 32.06, BP Sitting :140/84, Temp 97.9 F, Heart rate 56, Resp Rate 20.

Examination
Examination:
General appearance Alert, No acute distress, Pleasant. ENT Conjunctiva clear, Pupils equal and reactive to light and accomodation. Neck Non-tender, No lymphadenopathy. Heart Regular Rate and Rhythm, S1 S2 heard clearly. Lungs Clear to auscultation, Good air entry bilaterally, No wheezes, crackles or bronchi. Abdomen Soft, non-tender/Non-distended, No guarding or rigidity, No masses felt. extremities No edema.

Assessments
1. Hypertension - 401.9 (Primary)
2. Hyperlipidemia - 272.4
3. Constipation - 564.00
4. Vertigo - 438.85
5. Alzheimers disease - 331.0
6. Insomnia - 780.52

Treatment
1. Hypertension
Refill Metoprolol Succinate ER tablet, extended release, 100 mg, 1 tab(s), orally, once a day, 30 day(s), 30 Tablet, Refills 6
Refill amlodipine tablet, 10 mg, 1 tab(s), orally, once a day, 30 day(s), 30 Tablet, Refills 6
Notes: -pt said she has not taken her meds today yet.

2. Hyperlipidemia
Refill atorvastatin tablet, 40 mg, 1 tab(s), orally, once a day (at bedtime), 30 day(s), 30, Refills 6

3. Constipation
Refill Colace capsule, sodium 100 mg, 1 cap(s), orally, 2 times a day as needed for constipation, 30 day(s), 60, Refills 6
Start Citrucel powder for reconstitution, 2 g/19 g, 1 tablespoon, orally, in 8 ounce of cold water one a day as needed for constipation, 30 day(s), 1 Bottle, Refills 6
Notes: -change miralax to citrucel; continue colace
-advised fiber -rich foods, fruits/vegetables, oral fluids.

4. Vertigo
Refill Antivert tablet, 25 mg, 1 tab(s), orally, 2 times a day prn for dizziness, 30 day(s), 60, Refills 6
Notes: -sx well controlled with antivert prn.

5. Alzheimers disease
Continue Donepezil Hydrochloride tablet, 10 mg, 1 tab(s), orally, once a day after breakfast once completing course of 5mg tab
Notes: -continue ff-up with neuro
-advised pt's daughter to contact agency of choice regarding PCA services and I will fill out the PCA form once I receive it.

6. Insomnia
Refill Melatonin tablet, 5 mg, 1 tab(s), orally, once a day (at bedtime) as needed for insomnia, 30 day(s), 30, Refills 6
Notes: -sx improved with current med.

7. Others
Refill multivitamin tablet, Multiple Vitamins, 1 tab(s), orally, once a day, 30 day(s), 30 Tablet, Refills 6

Immunization
Influenza, seasonal, injectable : 0.5 mL (Not administered - Refused : Patient decision)

Follow Up
ff-up ~4-6 mos; sooner if sx fail to improve

Progress Notes

Patient: MATHES, MARGARET

Provider: Michael Bralower, MD

Date: 10/21/2014

Subjective:

Chief Complaints:

1. 68 y.o female here for neuro appt reg: memory loss eval c,cintron ma.

HPI:

Interpreter:

Interpreter Use By Provider of Care.

Medical History: 11/2011: carotid doppler - normal (Saints), 10/2011: MRI brain - lacunar infarct a right sup lateral ventric mrgin with smaller lesion on right parietal white matter , 9/2011: CT head - small old lacunar infarct - right corona radiata; no acut abn, 5/2013: declines mammogram, pap, dexa scan, 5/2013: stool guaiac neg, Memory loss.

Family History: Partner: deceasedFather: deceasedMother: deceasedPaternal Grand Father: deceasedPaternal Grand Mother: deceasedMaternal Grand Father: deceasedMaternal Grand Mother: deceasedSiblings: aliveChildren: alive1 sister(s) - healthy. 2daughter(s) - healthy.
no known cancers/stroke/heart disease/diabetes.

Social History: Smoking Status Are you a: nonsmoker. Other Drug Use Current drug use: No, Drug use history: No. Diet Caffeine use: Yes, Form: Coffee. Exercise: No Exercise. Marital Status Current status: Widowed. no Living Situation Lives with: Alone, Number of household member: 1. Employment and Income Employment Status: Retired. Travel and Immigration Recent travel outside of the United States: No, How long has patient lived in the United States(years)? 34 yrs, Age of arrival to the United States: 33 yo, Country of birth: Cambodia. Religion Practicing Christian Yes, Selection: Buddhist. Safety Seat belt / Car seat use: Yes, Home smoke detector use: Yes, Carbon monoxide detector use: Yes. Alcohol Use Current use: No, Alcohol use history: No, family use No. Do not use/ old Tobacco : Current tobacco use: No, Patient exposed to second hand smoke? No.
does not smoke/drink.

Medications: Taking Melatonin 5 mg tablet 1 tab(s) once a day (at bedtime) as needed for insomnia, Taking Metoprolol Succinate ER 100 mg tablet, extended release 1 tab (s) once a day, Taking amlodipine 10 mg tablet 1 tab(s) once a day, Taking atorvastatin 40 mg tablet 1 tab(s) once a day (at bedtime), Taking multivitamin Multiple Vitamins tablet 1 tab(s) once a day

Allergies: N.K.D.A.

Objective:

Vitals: Pain 0, Height 60, Weight 163, Weight Change 2 lb, BMI 31.83, BP Left Arm:119/77, Temp 99 F, Heart rate 63, Resp Rate 16, O2 saturation 96.

Examination:

Examination:

The patient is a 76-year-old right-handed female referred by Dr.Gayanilo for neurologic consultation because of progressive memory impairment. Patient's daughter acts as historian and translator patient's speaking Khmer emigrating from Cambodia in 1981. For approximately a year patient has had progressive deterioration or recent memory there've also been impairment and her cognition as well as activities of daily living i.e. daughter states that she could not complete a meal by herself and sometimes has to do my to change her closing. She was involved in 2 motor vehicle accidents one totaling her car fortunately not being injured and is no longer allowed to drive by her family since the onset of her symptoms patient has little insight into her problem there've been no behavioral problems she stopped and depressed she's had difficulty sleeping but this is improved on melatonin. Her remote memory appears to be much better preserved than her recent memory. She is now living with her daughter. Workup has included both an MRI and CAT scan of the brain which showed lacunar infarcts in the right corona radiata and parietal white matter small vessel vascular changes are noted in the white matter. There was no evidence of large vessel stroke. Patient has no history of TIA or stroke. B12 and TSH within normal limits. Patient has had no history of significant head trauma. She was given away at birth so no family history is available.

A neurologic assistance she did not complain of headache any additional cranial nerve symptomatology there is been no gait disturbance involuntary movements or weakness or sensory complaints she has not been incontinent.

Please refer to additional past medical history, medications, allergies, social and family history she noted a medication she is also on aspirin 325 mg per day.

Physical examination shows an elderly female in no distress there are no carotid bruits to be noticed she carotid ultrasound Doppler performed which showed no hemodynamic stenosis of either carotid artery with patent vertebral arteries. Please refer to vital signs. Neurologic examination she is mentally fully alert and awake she scored 18/29 on the Mini-Mental status examination she was oriented only to season her immediate recall is intact she is able to retain two out of three objects at 3 minutes one out of 3 objects in 5 minutes and none of 3 objects at 10 minutes her language function appear to be intact patient has had no formal education but was able to read and write in her native language. She was appropriate. She was unable to draw clock and had difficulty with serial category naming.

Stance and gait are normal

Cranial nerve examination shows sharp flat discs. Visual fields are full to confrontation. She can read print with either eye. Pupils are mid position both reactive to light. Eye movements are full without nystagmus. Facial sensation including coronary response and strength are normal. Hearing, gag reflex, tongue movements and x-rays are normal.

Stance and gait are normal. There is no weakness of her extremities. Reflex symmetric and of moderate activity except for depressed ankle jerks with plantar responses being flexor bilaterally. There are no pathologic reflexes.

Appendicular coordination is normal.

Sensation is normal to small, large cortical modalities. Romberg is negative.

Impression and comment: Patient's clinical presentation is consistent with a dementia probably Alzheimer's type and given the changes on her neuroimaging studies of the brain this may be a mixed type dementia pathologically of Alzheimer's disease and vascular type. I do not think this is a pure vascular cognitive impairment/dementia disorder given the lack of history of a TIA or stroke and her clinical history. Other symptomatic and treatable causes of dementia have been excluded per workup.

After a long discussion with the patient's daughter I've advised trial of donepezil ie Aricept beginning at 5 mg after breakfast for months and increasing to 10 mg a day side effects typically GI weight loss and to discuss. The limited expectations with this medication including no evidence that it prevents her progression of Alzheimer's disease or vascular dementia has been discussed. She is on treatment risk factors for cerebrovascular disease including hypertension and hyperlipidemia as well as antiplatelet therapy with aspirin which will be continued. Social, nutritional and safety issues are presently being met with the patient living with her daughter. The dura was fully where the patient can no longer operate a motor vehicle. I have encouraged reading card games and puzzles. We have discussed dementia including Alzheimer's disease and risk factors for vascular dementia at length and followup appointment has been scheduled.

Assessment:

Assessment:

1. Alzheimers disease - 331.0 (Primary)

Plan: